STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155356	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL CARE UNIT OF ST JOSEPH	700 BROADWAY FORT WAYNE, IN46802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000		F0000		

This visit was for the Recertification and State Licensure Survey.

Survey dates: May 11 and 12, 2011

Facility number: 000247
Provider number: 155356
AIM number: N/A

Survey team:
Julie Wagoner, RN, TC
Tim Long, RN

Census bed type:
SNF: 16
Total: 16

Census payor type:
Medicare: 12
Other: 4
Total: 16

Sample: 08

These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.

Quality review completed 5/19/11 by Jennie Bartelt, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0156 SS=C	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to ensure Medicare/Medicaid information was visibly posted and available for 16 of 16 residents residing in the facility. Findings include: During the Environmental Tour of the facility, conducted on 05/12/11 at 10:15 A.M. - 11:00 A.M., with the Maintenance Director, Employee #8, the posting of Medicare/Medicaid information could not be located. During interview at that time, Employee #8 indicated he was unaware of what the posting was supposed to be or where it was located. The Administrator was interviewed on 05/12/11 at 11:00 A.M., and indicated the information was posted on the bulletin board adjacent to the main elevators for the unit. However, observation of the bulletin board at this time revealed there was only a posting of the long term care Ombudsman's name and contact information. 3.1-4(l)(1) 3.1-4(l)(2)	F0156	Immediate Correction:1. No residents were found to be negatively affected by the deficient practice identified. Employee #8 was educated on the Medicare/Medicaid information posting and the location on 05/12/2011.Written information on Medicare/Medicaid has been promptly displayed on the unit as soon as it was identified during the survey process on 05/12/20112. No residents were found to be negatively affected by the deficient practice identified. All 16/16 patients on 05/12/2011 received a handout of Medicare/Medicaid information. Corrective Action: 3. All Transitional Care Unit Staff will be educated on the Medicare/Medicaid Information Posting and its location by June 7th 2011. Monitoring of Corrective Action: 4. Administrator or designee will audit that the Medicare/Medicaid information is posted prominently	06/07/2011

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			and reviewed weekly X 4 and monthly X 2 starting 05/23/2011Results of these audits will be reviewed at the Quarterly Quality Assurance (QA) meetings to identify any issues or trend. If any issues are identified, ongoing monitoring will be completed for an additional 3 month period. The threshold for compliance will be 100% at the end of the initial monitoring period. Additional corrective action needed will be determined by the QA Committee if compliance rate is below 100%.	
F0252 SS=D	The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Based on observation and interview, the facility failed to ensure the exhaust vents were cleaned for 3 of 5 vents observed during the Environmental tour. This deficient practice affected 3 of 8 residents in a sample of 8. (Residents #15, 10, and 2) Findings include: During the Environmental Tour of the facility, conducted on 05/12/11 between 10:15 A.M. - 11:00 A.M., the bathroom exhaust vents in the bathrooms in resident rooms #908, 919, and 923 were oberved to be covered with a thick layer of dust. Interview with the Maintenance Director,	F0252	Immediate Correction: 1. No residents were found to be negatively affected by the deficient practice identified. Exhaust vents in bathrooms in resident rooms # 908, 919 and 923 were cleaned to provide a safe, clean, comfortable and home like environment on 05/13/20112. No residents were found to be negatively affected by the deficient practice identified. In addition, ALL Resident room bathroom vents were checked and cleaned to ensure all reidents were provided with safe, clean, comfortable and home like environment on 05/13/2011Corrective Action: 3. Education to Housekeeping staff on practices related to a safe, clean, home like environment including but not limited to	06/07/2011

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	Employee #8, during the Environmental Tour of the facility, indicated the vents were dirty. 3.1-19(f)		cleaning of exhaust vents in the bathrooms of resident rooms by June 7th 2011. Assigned Housekeeping Staff will ensure weekly cleaning of all bathroom vents by June 7th 2011Monitoring of Corrective Action: 4. Director of Environmental Services or designee will ensure 100% weekly audits of all resident bathrooms to ensure cleanliness of the exhaust vents. This will be continued for weekly X 4 and monthly X 2 starting the week of June 6 2011Results of these audits will be reviewed at the Quarterly Quality Assurance (QA) meetings to identify any issues or trend. If any issues are identified, ongoing monitoring will be completed for an additional 3 month period. The threshold for compliance will be 100% at the end of the initial monitoring period. Additional corrective action needed will be determined by the QA Committee if compliance rate is below 100%.	

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure the drug regimen for 1 of 3 residents reviewed for psychoactive medications in a sample of 8, was free from medication in excessive dose. (Resident #2) Findings include: During interview on the initial tour of the facility, conducted on 05/11/11 at 10:00 A.M., RN #5 indicated Resident #2 had been admitted to the facility due to congestive heart failure. She indicated the resident was also diabetic.	F0329	Immediate Correction: 1. Contacted the attending Physician of Resident # 2 on 05/12/2011 and reviewed drug regimen. Subsequently, we received documentation including diagnoses,clinical indication for use and orders for initial reduction in dosage. 2. No other residents were found to be negatively affected by the deficient practice identified. In addition, the drug regimen of all current patients with psychoactive medications were reviewed on 05/24/2011 by the multidisciplinary team inclusive of Medical Director and Pharmacist to ensure regimen is free from unnecessary drugs or excessive duration or without	06/07/2011

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	The clinical record for Resident #2 was reviewed on 05/12/11 at 9:53 A.M. The resident was admitted to the facility on 05/06/11 with diagnosis, including but not limited to, congestive heart failure, devility, weakness, and edema. The resident had physician's orders on admission to the facility for the antiaxiety medication, Lorazepam 2 mg, at bedtime. There was no documentation in the patient's history, nursing notes, or physician notes regarding why the resident was receiving the antianxiety medication, Lorazepam. Interview with the casemanager for the long term care unit, RN #9, on 05/12/11 at 11:35 A.M. indicated she was unaware the resident received antianxiety medication but thought since it was given at bedtime possibly it was for sleep issues. She indicated the resident had been receiving the medication while at home prior to her acute care stay. Interview with the pharmacist, Employee #10, on 05/12/11 at 2:40 P.M. indicated the physician had been notified and indicated the Lorazepam was given for insomnia and restlessness. The pharmacist indicated the medication had been recommended after a psychiatric evaluation, but it was unclear if the		adequate monitoring; or without indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Corrective Action: 3. All patients on psychoactive medications will be reviewed weekly effective 05/24/2011 at the multidisciplinary team meetings which includes the Medical Director. Effective 05/24/2011, for patients with length of stay greater than 30 days, will have a monthly medication regimen review by the pharmacist to evaluate the resident related information for dose, duration, continued need, and the emergence of adverse consequences of all medications. Policy for usage of psychoactive Medication will be reimplemented by June 7th 2011 and all Pharmacy and Nursing staff will be educated on this policy by June 7th 2011. Ongoing Monitoring of Corrective Action: 4. Director of Nursing/Designee will audit all patients on psychoactive medications weekly X 4 and monthly X 2 starting 05/24/2011 to ensure they have been reviewed by the multidisciplinary team. Results of these audits will be reviewed at the Quarterly Quality Assurance (QA) meetings to identify any issues or trend. If any issues are identified, ongoing monitoring will be completed for	

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	evaluation had been completed with the resident's most recent acute care hospitalization or a previous hospitalization. It was also unclear and there was no specific documentation provided to support the use of 2 mg of Lorazepam for insomnia when the recommended maximum dose was 1 mg of Lorazepam. The pharmacist indicated the medications had been reviewed when the medications were dispensed but a more thorough medication review would not be completed until the resident had been in the facility for one month. He indicated he did not know why a "little 90 year old lady" was prescribed such a large dose of Lorazepam. The Director of Nursing indicated during interview on 05/12/11 at 1:40 P.M., that she could not locate a specific policy regarding psychoactive medications. 3.1-48(a)(1) 3.1-48(a)(4)		an additional 3 month period. The threshold for compliance will be 95% at the end of the initial monitoring period. Additional corrective action needed will be determined by the QA Committee if compliance rate is below 95%.	

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure 3 of 4 licensed nurses observed obtaining blood glucose levels followed instructions for proper sanitation of the glucometers	F0441	Immediate Correction: 1. No residents were found to be negatively affected by the deficient practice identified. RN # 1, RN # 2 and RN # 3 were educated on PDI Super Sanicloth	06/07/2011

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	for 2 of 5 residents observed during the medication administration pass. (Residents #9 and 3) The facility also failed to ensure 1 of 1 housekeepers observed disinfected hard surfaces properly for 1 of 8 residents in a sample of 8. (Resident #10) Findings include: During observation of blood glucose measurements on 5/11/11 at 11:30 A.M., RN #1 wiped off the outside of the glucometer with Super Sani Wipes for 5 seconds and let the machine dry for 2 minutes. RN #1 proceeded to check Resident #9's blood glucose. During observation of blood glucose measurements on 5/11/11 at 4:40 P.M., RN #2 wiped off the outside of the glucometer with Super Sani Wipes for 15 seconds and let the machine air dry for 2 minutes. RN #2 proceeded to check Resident #3' s blood glucose. During observation of blood glucose measurements on 5/11/11 at 5:12 P.M., RN #3 wiped off the outside of the glucometer with Super Sani Wipes for 5 seconds and let the machine air dry for 2 minutes. RN #3 proceeded to check Resident #9's blood glucose. Review of the instructions for the Super Sani Wipes indicated, "Treated surface must remain visibly wet for a full two (2) minutes. Use additional wipe(s) if needed." Review of the facility policy/procedure, subject "enhanced cleaning and decontamination of the		Wipes usage to ensure adherence to manufacturer guidelines of keeping the treated surface visibly wet for 2 minutes on 05/12/2011. Employee # 7 was educated on usage of 3M23 disinfectant and ensure adherance to manufacturer guidelines of keeping the treated surface visibly wet for 10 minutes on 05/12/2011. 2. No residents were found to be negatively affected by the deficient practice identified. All Staff present on 05/12/2011 were educated on PDI Super Sanicloth Wipes usage to ensure adherence to manufacturer guidelines of keeping the treated surface visibly wet for 2 minutes. All House Keeping Staff present on 05/12/2011 were educated on usage of 3M23 disinfectant and ensure adherance to manufacturer guidelines of keeping the treated surface visibly wet for 10 minutes. Corrective Action: 3. All Nursing Staff will be educated on PDI Super Sanicloth Wipes usage to ensure adherence to manufacturer guidelines of keeping the treated surface visibly wet for 2 minutes by June 7th 2011. All Housekeeping staff will be educated on usage of 3M23 disinfectant and ensure adherance to manufacturer guidelines of keeping the treated surface visibly wet for 10 minutes by June 7th 2011. Monitoring of	

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	patient environment and non-critical patient care equipment" dated 3/3/10, provided by the Administrator as current, indicated: "treated surfaces must remain visibly wet for 2 minutes for disinfection to be effective. Let air dry". 2. During the Environmental Tour of the facility, conducted on 05/12/11 at 10:15 P.M., housekeeper, Employee #7, indicated during interview, she utilized a "wipe" to sanitize hard surfaces such as an overbed table. She indicated she saturated her container of dry wipes with cleaner 3M23. The bottle of 3M23 disinfectant was observed in the utility closet on 05/12/11 at 11:00 A.M. Interview with the Maintenance Director, Employee #8, and review of the instructions for use indicated the disinfectant was supposed to remain "wet" on surfaces for 10 minutes. Employee #7 was observed wiping down an overbed table in a Resident #10's room. The surface was directly observed and was noted to be approximately 50 percent dry after 5 minutes of time had elapsed. After 7 minutes had elapsed, the surface of the overbed table was approximately 80 percent dry. At 10 minutes of time, only approximately 3 percent of the table top surface remained wet. 3.1-18(b)(2) \		Corrective Action: 4. The Director of Nursing or designee will observe 5 licensed nurses every week starting the week of June 6th 2011 X 4 and monthly X 2 for compliance with manufacturer guidelines of keeping the treated surface visibly wet for 2 minutes. The Director of Facilities or designee will observe the housekeeper assigned to the Transitional Care Unit every week starting the week of June 6th 2011 X 4 and monthly X 2 for compliance with manufacturer guidelines of keeping the treated surface visibly wet for 10 minutes. Results of these audits will be reviewed at the Quarterly Quality Assurance (QA) meetings to identify any issues or trend. If any issues are identified, ongoing monitoring will be completed for an additional 3 month period. The threshold for compliance will be 100% at the end of the initial monitoring period. Additional corrective action needed will be determined by the QA Committee if compliance rate is below 100%.	

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